CALIFORNIA'S HEALTH

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STATE DEPARTMENT OF PUBLIC HEALTH
ESTABLISHED APRIL 15, 1870

PUBLISHED SEMI-MONTHLY

ENTERED AS SECOND-CLASS MATTER FEB. 21, 1922, AT THE POST OFFICE AT SACRAMENTO, CALIFORNIA, UNDER THE ACT OF AUG. 24, 1912. ACCEPTANCE FOR MAILING AT THE SPECIAL RATE OF POSTAGE PROVIDED FOR IN SECTION 1103, ACT OF OCT. 3, 1917

SACRAMENTO (14), 631 J STREET, 2-4711   SAN FRANCISCO (2), 668 PHELAN BLDG., 760 MARKET ST., UN 8700   LOS ANGELES (12), STATE OFFICE BLDG., 217 W. FIRST ST., MA 1271

VOLUME 5, NUMBER 14   JANUARY 31, 1948

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A State-wide Plan For Hospital Construction In California*

The Hospital Survey and Construction Act

A state-wide plan for hospital and health center construction in California has been developed in conformity with the provisions of the Hospital Survey and Construction Act (Public Law 725), which was passed by the 79th Congress on August 13, 1946. (This law is sometimes referred to as the Hill-Burton Bill.)

The Surgeon-General of the United States Public Health Service was given the responsibility for administering this law. His duties include:

1. Appointment of the Federal Hospital Council with broad powers of advice and control;

2. Promulgation of regulations covering general policies in order to carry out the provisions of the law;

3. Direction of the several states in their programs of compliance with the law;

4. Distribution of funds for planning and construction.

Some of the provisions of Public Law 725 are as follows:

1. A single department of the state government shall be designated by the Governor as the state agency to administer the law on the state level.

2. The state agency shall make a survey of all existing hospitals and public health facilities in the State.

3. The state agency shall develop a plan of construction of hospitals and health centers, based on the survey and in conformity with the law.

4. The state agency shall assist in the clearing of applications for federal aid and in the distribution of approved funds.

5. Authorized an appropriation of $3,000,000 as grants-in-aid to states in making the survey and developing the construction plan, each state being required to match money in the ratio of two for one.

6. Authorized an appropriation of $75,000,000 each year for five years, on a construction obligation basis, for grants for the construction of hospitals in the proportion of one-third federal funds and two-thirds state and local funds, special consideration to be given to rural communities and to those with limited financial resources in awarding priorities for construction.

7. Assistance shall be given to governmental and non-profit hospitals.

8. Hospitals that receive aid shall not discriminate because of race, color, or creed.

9. A reasonable amount of service shall be rendered to those unable to pay in full.

10. Federal funds shall be available to the several states in proportion to their population and to their per capita income. (California will receive $1,957,575 per year for five years on the basis of present authorization and formula.)

The standard for determining the number of beds which may be built in a state with federal assistance funds are established by Public Law 725 as follows:

(a) For general beds, 4.5 per thousand population in states having 12 or more persons per square mile;

*** An excerpt from Chapter I of a forthcoming report, "Hospital Facilities in California, Revised Report" to be issued by the California State Department of Public Health.**

(b) For tuberculosis patients, 2.5 times the average annual deaths from tuberculosis in the state, over the five-year period from 1940 to 1944 inclusive;

(c) For chronic disease patients, 2 per thousand population;

(d) For mental patients, 5 per thousand population.

Development of a State-wide Hospital Plan

The California State Legislature, by the Hospital Survey and Construction Act (Chapter 327, Statutes of 1947), designated the Department of Public Health as the state agency to carry out the provisions of the federal act on the state level. The department has completed its survey of existing hospital and public health facilities in the State, and has developed a statewide plan for an integrated hospital and public health system, based on the survey and in conformity with the federal law. The federal law requires that the Surgeon-General of the United States Public Health Service approve all state plans. California's plan was approved as submitted on November 10, 1947.

The federal regulations require that, when the inventory of existing facilities is listed, each hospital be designated as "acceptable" or "nonacceptable" in a long-range hospital construction program. The designation "nonacceptable" does not mean that patients in those beds do not receive good care, but that the construction of the building does not meet the standards of modern hospital buildings in respect to fire hazards, undesirable location, structural unsuitability, etc. The following criteria for determining "nonacceptable" beds, which have been adopted more or less uniformly by all states, are as follows:

1. Aged buildings, including all structures built prior to 1900.
2. Parts of buildings constructed or additional stories to non-fire resistive structures.
3. Buildings (or portions thereof) not constructed as hospitals.
4. Small additions meeting present standards but which cannot serve as the basis of a new building by reason of location or arrangement.
5. Non-fire resistive buildings.
6. Buildings located where objectionable nuisances exist which cannot be corrected.

Federal funds may be used to replace "nonacceptable" beds. However, the federal regulations state that initial installations and additions to existing hospitals and health centers shall be given priority over replacements except:

(a) Where replacement is of minor character and necessary to the provision of needed additional facilities;

(b) Where, in the case of a hospital, replacement is essential to eliminate an existing needed hospital which constitutes a public hazard;

(c) Where, in the case of a public health center, the state health authority has certified that the existing facility is unsuitable for use as a public health center.

The Attorney General of California has ruled that the State Fire Marshal has the responsibility for determining whether or not a hospital building is fire-resistive. If a building, which has been classified as nonacceptable only because it is non-fire resistive, is subsequently altered to meet the requirements of the Fire Marshal, it shall be reclassified as "acceptable."

The federal regulations require that in compiling the population of the State, or any area thereof, the state agency shall use the latest figures of civilian population certified by the Federal Department of Commerce. The latest estimate of the civilian population of California certified by the federal agency is 9,342,036 for 1946. A provisional estimate of 9,751,000 is available for 1947, but this figure cannot be used until final certification is made.

Using the 1946 population and applying the standards established by Public Law 725, which are given above, a summary of the hospital facilities in California may be stated as follows:

	Estimated need	*Available acceptable*	*Shortage (including replacements)*
General and allied special	42,039	20,568	21,471
Mental	46,710	28,310	18,400
Tuberculosis	9,598	2,231	7,367
Chronic	18,684	3,434	15,250
Total	117,031	54,543	62,488

Included in the 62,488 bed shortage are 17,939 beds which either should be replaced or will require alterations in order to be classified as "acceptable."

In developing a state plan, a three-fold purpose was kept in mind:

1. To plan an integrated system of complementary services which will provide general hospital facilities within one hour's travel time from the home of every citizen in the State.

2. To plan for more adequate facilities for individuals afflicted with tuberculosis, mental disorders and chronic diseases.

3. To plan for the expansion of public health facilities in a manner that will increase the efficiency of the agency which deals with the prevention of disease, and will make it more accessible to the public.

To accomplish these purposes, the State was divided into 16 regions and 83 general hospital service areas. These areas are of three types: base, intermediate and rural. They are defined by the U. S. Public Health Service regulations as follows:

1. A base area must have a population of 100,000 or more and contain a hospital of 200 or more beds which is equipped to handle every kind of acute illness. It is preferable that the area contain the teaching hospital of a medical school. Under this definition, there are two such areas in California: one in Los Angeles, the other in San Francisco.

2. An intermediate area must have at least 25,000 population and contain a hospital of 100 beds or more equipped for the diagnosis and treatment of all but the most specialized illnesses.

3. A rural area may not have more than 25,000 population.

These areas have been grouped into regions with the largest medical center in the region designated as the regional center. It is hoped that, as the construction program progresses, a system can be developed whereby the medical staff of the large regional hospital will provide consultation, diagnostic services, and specialized treatment to patients in smaller institutions. Under such a system, physicians of the community hospitals would be privileged to refer and to attend their patients in the regional hospitals under the regulations of the staffs of those hospitals. Members of the governing boards of the smaller institutions would be members of, or meet with, the boards of the larger hospitals in the interest of continuing education. It is hoped that mutual cooperation between the different hospitals will lead to an integrated system of improved care and encourage a wider distribution of trained personnel.

The federal law requires that the area with the greatest need and the least financial resources among rural areas be given first consideration in the allocation of funds. The law further provides that each state may receive aid on a maximum of 4.5 beds per thousand population, while each base area may receive aid for the same number (4.5 beds per thousand); the intermediate area, 4.0 beds per thousand; and the rural area, 2.5 beds per thousand. Since the intermediate and rural areas do not use the State allowance, the balance of these beds becomes a pool from which beds may be allocated to areas that need additional beds for any reason, such as industrial hazards, travel hazards, large transient populations, military areas, medical teaching centers, or other factors.

Priorities

The actual need for general hospital beds in each area was determined by the above criteria. Then it was necessary to find what portion of that need was met by existing acceptable facilities. The number of existing acceptable beds was divided by the number of beds needed by that area to compute the percent of need met by existing acceptable facilities. The percent of need met by existing facilities in each area is as follows:

Base Areas

Area	*Percent of need met*	*Area*	*Percent of need met*
B1	81	B2	51

Intermediate Areas

Area	*Percent of need met*	*Area*	*Percent of need met*
1- 1	54	1-20	28
1- 2	24	1-21	24
1- 3	54	1-22	80
1- 4	77	1-23	53
1- 5	73	1-24	19
1- 6	73	1-25	20
1- 7	51	1-26	53
1- 8	37	1-27	50
1- 9	72	1-28	47
1-10	72	1-29	70
1-11	14	1-30	73
1-12	41	1-31	100
1-13	11	1-32	44
1-14	100	1-33	43
1-15	39	1-34	76
1-16	16	1-35	67
1-17	0	1-36	31
1-18	43	1-37	49
1-19	64		

Rural Areas

Area	*Percent of need met*	*Area*	*Percent of need met*
R- 1	0	R-24	0
R- 2	0	R-25	0
R- 3	48	R-26	59
R- 4	0	R-27	8
R- 5	0	R-28	0
R- 6	0	R-29	100
R- 7	26	R-30	62
R- 8	25	R-31	74
R- 9	44	R-32	0
R-10	0	R-33	8
R-11	64	R-34	0
R-12	0	R-35	54
R-13	100	R-36	43
R-14	100	R-37	67
R-15	0	R-38	92
R-16	97	R-39	0
R-17	20	R-40	13
R-18	11	R-41	0
R-19	81	R-42	17
R-20	52	R-43	15
R-21	100	R-44	18
R-22	0	R-45	0
R-23	65		

The boundaries and the identifying numbers of the service areas are shown on the map below.

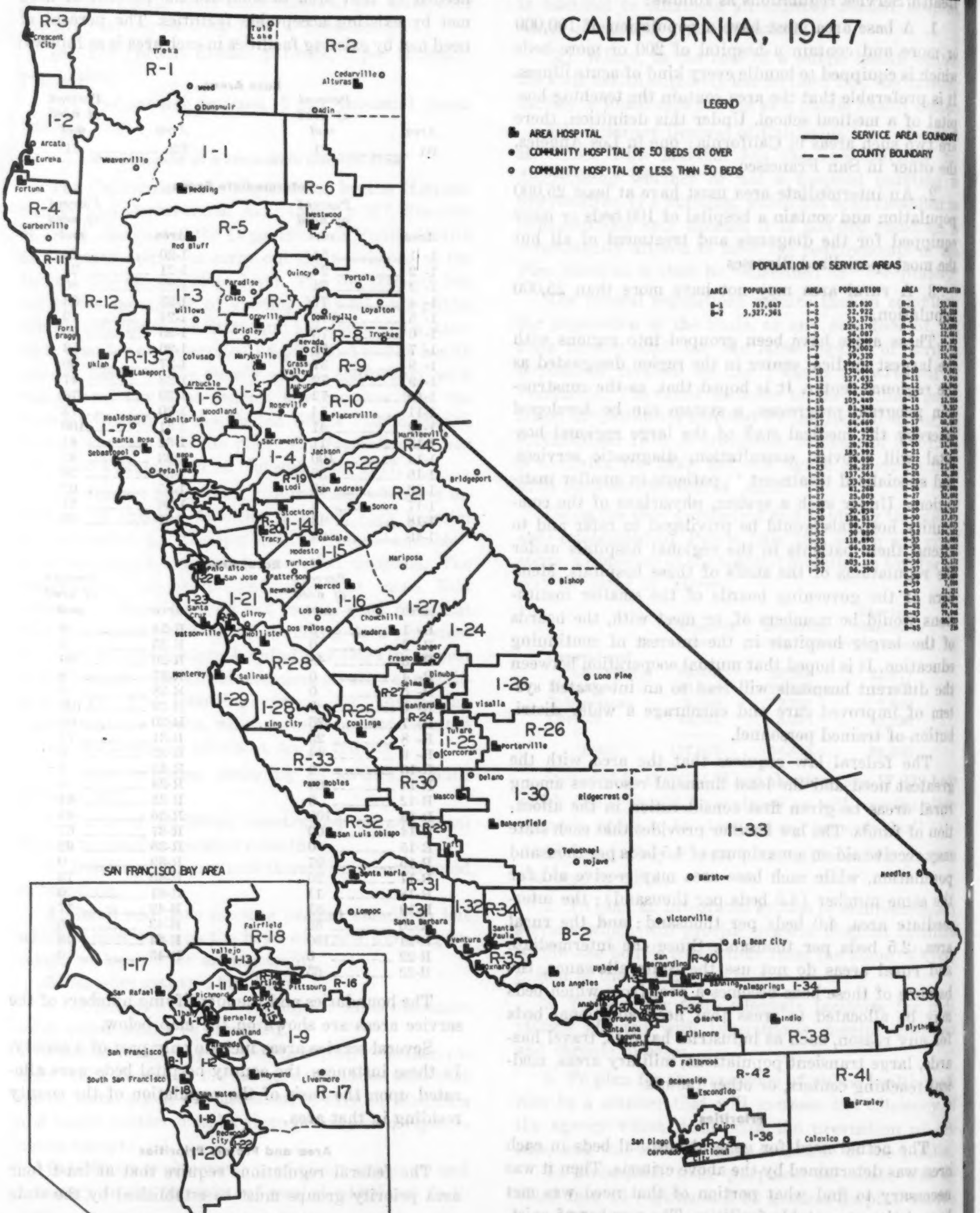
Several service areas include only part of a county. In these instances, the county hospital beds were allocated upon the basis of the population of the county residing in that area.

Area and Project Priorities

The federal regulations require that at least four area priority groups must be established by the state

(Continued on page 305)

GENERAL HOSPITAL SERVICE AREA
CALIFORNIA, 1947



SOURCE: California State Department of Public Health, Hospital Schedules of Information, 1947.

POPULATION OF SERVICE AREAS

AREA	POPULATION	AREA	POPULATION	AREA	POPULATION
B-1	767,647	I-1	28,920	R-1	[illegible]
B-2	3,327,361	I-2	32,922	R-2	[illegible]
		I-3	33,574	R-3	[illegible]
		I-4	326,170	R-4	[illegible]
		I-5	36,087	R-5	[illegible]
		I-6	30,309	R-6	[illegible]
		I-7	73,002	R-7	[illegible]
		I-8	39,320	R-8	[illegible]
		I-9	396,626	R-9	[illegible]
		I-10	154,066	R-10	[illegible]
		I-11	327,631	R-11	[illegible]
		I-12	85,230	R-12	[illegible]
		I-13	98,840	R-13	[illegible]
		I-14	103,449	R-14	[illegible]
		I-15	81,388	R-15	[illegible]
		I-16	89,766	R-16	[illegible]
		I-17	64,669	R-17	[illegible]
		I-18	86,436	R-18	[illegible]
		I-19	59,723	R-19	[illegible]
		I-20	28,782	R-20	[illegible]
		I-21	183,992	R-21	[illegible]
		I-22	28,030	R-22	[illegible]
		I-23	26,227	R-23	[illegible]
		I-24	337,361	R-24	[illegible]
		I-25	33,041	R-25	[illegible]
		I-26	81,268	R-26	[illegible]
		I-27	25,009	R-27	[illegible]
		I-28	43,399	R-28	[illegible]
		I-29	30,836	R-29	[illegible]
		I-30	128,517	R-30	[illegible]
		I-31	56,726	R-31	[illegible]
		I-32	30,859	R-32	[illegible]
		I-33	118,890	R-33	[illegible]
		I-34	66,022	R-34	[illegible]
		I-35	42,944	R-35	[illegible]
		I-36	803,116	R-36	[illegible]
		I-37	94,290	R-37	[illegible]
				R-38	[illegible]
				R-39	7,000
				R-40	21,231
				R-41	[illegible]
				R-42	[illegible]
				R-43	[illegible]
				R-44	[illegible]
				R-45	[illegible]

Hospital Construction Plan—Continued

agency. The priority groups and the range of percent of need met in each group in California is as follows:

Priority group	*Range of percent of need met*	*Priority group*	*Range of percent of need met*
A	0- 24	C	50- 74
B	25- 49	D	75-100

Priorities for individual projects are to be established at the time the project's construction schedule is submitted. This schedule cannot be submitted by the state agency to the United States Public Health Service until four months after the state plan has been approved by the Surgeon-General. This period of time is required to allow sponsoring agencies a reasonable time after approval of the state plan to develop a construction interest and furnish assurance of the availability of funds. Factors to be considered in approving projects are the area priority, the intent of sponsoring agencies to begin construction within a reasonable time, and the availability of funds for the construction, maintenance and operation of the facility.

The Advisory Hospital Council which was appointed by the Governor to advise and assist the Department of Public Health, has indicated that funds for the first year shall be allocated to the construction of general hospital beds, due to the acute shortage in this category. Subsequently, appropriations will be made to the other types of facilities, i.e., tuberculosis, chronic, and nervous and mental, so that at the end of the five-year construction program there will be an adequate balance between these categories in the State of California.

Duplicate copies of the state plan, as submitted to and approved by the Surgeon-General, are available for public reference in the Los Angeles and San Francisco offices of the California State Department of Public Health.

(A report on the "Plan for Health Center Construction" will appear in a subsequent issue of *California's Health*.)

San Mateo Hospital Approved for Tuberculosis Subsidy

The San Mateo Community Hospital has been approved for tuberculosis subsidy payments by the State Board of Public Health.

This action marks the first time a general hospital has been approved for such funds, but is in keeping with a general policy of the Tuberculosis Service of the department to encourage general hospitals to provide for the care of tuberculosis cases wherever they meet the standards established for sanitoria receiving state subsidy.

Mrs. Valerie Higby

Public health lost a devoted worker with the death on January 6th of Mrs. Valerie Higby, wife of W. Ford Higby, executive secretary of the California Tuberculosis and Health Association.

A social worker by profession, Mrs. Higby was one of a small group in the State who took leadership in the development of the California Conference of Social Work and in the establishment of professional standards for personnel in this field.

In recent years she gave tireless volunteer service to social work and public health organizations. Although she was seriously ill at the time, Mrs. Higby carried on as usual in making the arrangements for the meeting in San Francisco last May of Western Branch, American Public Health Association.

L. A. County to Observe "Disease Prevention Week"

Los Angeles County will observe its annual "Disease Prevention Week" from February 15th-22d.

Speakers at meetings to be held throughout the eight-day period will urge vaccinations against smallpox and immunizations against diphtheria, whooping cough and tetanus. Prevention of tuberculosis and venereal disease will also be stressed.

"Disease Control Week" is an annual activity of the Community Health Association of Los Angeles carried out in cooperation with the County and City Health Departments, American Red Cross, public schools, parent-teacher groups and other social and welfare organizations.

1947 Rodent Survey Totals

During 1947 plague survey crews of the State Department of Public Health collected 38,206 rodents from all sections of the State for laboratory examination. Ectoparasites collected from these rodents included 321,688 fleas, 457 ticks, and 5,491 lice.

Index to Volume IV Ready

The index to Volume IV (July 1946-June 1947) of *California's Health* is now available for distribution. All interested individuals or groups may obtain copies by addressing requests to: Bureau of Health Education, 760 Market Street, San Francisco 2, California.

A limited number of indexes to Volume III are also available and will be sent on request.

Type "A" Influenza Identified: Mass Vaccinations Not Recommended

Type A influenza was demonstrated to be present in most of California during December by the State Viral and Rickettsial Disease Laboratory.

The State Department of Public Health is not recommending mass vaccination programs at this time, but has requested acute and convalescent blood specimens from cases reported. The specimens (10 c.c. each) of acute and convalescent blood should be sent to: The Viral and Rickettsial Disease Laboratory, California State Department of Public Health, 1392 University Avenue, Berkeley 2, California.

Epidemiologic evidence indicates that the disease first appeared in the desert of Riverside and San Bernardino Counties early in December and reached a peak in Los Angeles County around Christmas time. Other areas of the State, particularly the San Joaquin Valley, were likewise affected. The large number of cases of a mysterious "virus X" illness which were reported by Los Angeles newspapers at the time was probably due to a combined total of cases of influenza, illness due to epidemic nausea, vomiting and diarrhea, plus the common cold and other respiratory diseases.

There has not been reported an increased number of cases of pneumonia from this epidemic so far, although such complications as sinusitis and bronchitis, have been common among the observed cases.

Mass Vaccinations

Mass vaccinations are not recommended since, in the opinion of experts, they will not give the desired protection to any group after an epidemic of influenza has begun. At least 10 days are required to attain antibody substances and many recently vaccinated individuals will contract the disease during this time interval because of the short incubation period of 48 to 72 hours. Attention is again called to the fact that less than 15 percent of the population will be affected during an outbreak, so that there must be wide-scale protection of a group before any signs of the disease appears in order to gain substantial protection. Moreover, recent work with vaccinated and control groups call our attention to the importance of antiviral substances in the nasal secretions. Until greater knowledge concerning the antigenic variation among influenza A strains is developed and the ability to predict epidemics in advance is gained, mass vaccination programs against influenza will not be recommended by this department.

The healthy know not of their health, but only the sick.—*Carlyle*

Kings County Health Officer

Dr. Joseph H. Stickler has been appointed the first full-time health officer of Kings County. He succeeds Dr. Paul Murphy, who was acting health officer.

Dr. Stickler holds an M.P.H. from Johns Hopkins University, and since graduation has spent several years with the United States Indian Service and with the United States Army.

Department Consultants for 1948

The following consultants to this department for 1948 have been appointed by the State Board of Public Health.

Adult Health: Rutherford T. Johnstone, M.D.; *Animal Industry:* C. M. Haring, D.V.S.; *Bacteriology:* John F. Kessel, Ph.D., E. W. Schultz, M.D., R. V. Stone, D.V.M.; *Cerebral Palsy:* Margaret Jones, M.D.; *Dental Health:* Hugo M. Kulstad, D.D.S.; *Entomology:* W. B. Hermes, Sc.D.

General Consultant: Karl F. Meyer, M.D.; *Health Education:* Walter Brown, M.D., Dorothy Nyswander, Ph.D., W. B. Ryan (Radio), W. P. Shepard, M.D., Walter F. Wanger (Motion Pictures); *Hospital Administration:* Anthony J. J. Rourke, M.D.; *Orthopedics:* Leroy Abbott, M.D., Charles Le Roy Lowman, M.D., John C. Wilson, M.D.

Parasitology: Herbert G. Johnstone, Ph.D.; *Public Health Statistics:* E. L. Lucia, Ph.D.; *Rheumatic Fever:* Harold Rosenblum, M.D.; *Virus Laboratory:* Henry B. Bruyn, M.D.

$20,000 for Tumor Registries

A special grant of $20,000 has been received by this department from the National Cancer Institute for the development of tumor record registries in private and public hospitals in California.

These funds will be used during the coming year by the Chronic Disease Service to expand the tumor registry program, in which eight hospitals in the State are already participating.

More Health Departments Qualify

Health departments serving San Francisco, San Mateo, Ventura, Kern, Contra Costa and Mariposa Counties have been added to the list of those certified for State local health administration funds under the provisions of Chapter 8 of Part 1, Division 2 of the Health and Safety Code. This brings the total number of qualifying health departments (as of January 1st) to 42.

Two State Departments Integrate Industrial Health Services

Formalizing cooperative relationships which have existed between the two agencies for a number of years, the State Departments of Industrial Relations and Public Health recently adopted a plan for the integration and definition of their respective responsibilities for the health and safety of industrial workers in California.

Basing their plan on their responsibilities and authority under the Labor and the Health and Safety Codes, the following definition of independent and mutual responsibilities was adopted on November 24, 1947, by the heads of the two agencies, Paul Scharrenberg, Director of Industrial Relations, and Wilton L. Halverson, M.D., Director of Public Health:

Law Enforcement

The Department of Industrial Relations shall have entire authority in the enforcement of its orders and the responsibility for enforcing compliance with recommendations bearing on the health of industrial workers made by the Department of Public Health as far as such recommendations are covered by the published orders of the Department of Industrial Relations.

The Department of Public Health has the authority to abate nuisances. When these arise in relation to industrial health and hygiene, it may be called upon to exercise that authority.

Investigations and Studies

Studies for the evaluation of occupational health problems will be made by the Department of Public Health on (1) the referral of the Department of Industrial Relations, or (2) the request or sanction of either management or labor, or (3) its own initiative.

On the request of the Department of Industrial Relations, the Department of Public Health will provide technical assistance in support of any prosecution of violation of Industrial Relations orders or claim for compensation in which the Department of Public Health has reported supporting findings.

Availability of Preventive Medical and Accident Prevention Services

Subject to mutual agreement each department will make available to the other the following services:

Department of Industrial Relations—Formulation and promotion of orders, standards, policies, procedures, etc., for the prevention of industrial injuries; education in safe working practices; compilation and analysis of industrial injury statistics; establishment of standards pertaining to the employment of women and minors, and adjudication of workmen's compensation claims.

Department of Public Health—Promotion and improvement of plant medical and nursing services, direct medical consultation service to industrial plants, assistance with the control of communicable disease among the industrial population, assistance with the control of absenteeism from sickness, health education, analytical laboratory service, assistance with occupational disease control and environmental conditions of industry, and the services of specialized personnel, including industrial nurses, engineers, physicians, chemists and sanitarians.

Promulgation of Orders

Orders concerning health and sanitation standards in industry issued by the Department of Industrial Relations will be formulated and reviewed with the consultation of the Department of Public Health.

Joint Conferences

Emphasizing that consultation and cooperation are the means for achieving an integrated industrial health and safety program within the State, the plan calls for official periodic joint conferences between the administrative personnel of the divisions concerned for:

1. Promotion of better service to, and relations with industry.
2. Promotion, where possible, of parallel lines of emphasis in the study and inspection of particular health and accident hazards.
3. Presentation of consistent recommendations and requirements to employers where both departments have simultaneously been in touch with the same employer.
4. Correlation and integration of report forms, and of statistics.
5. Joint programs of dissemination of information, including inservice training for the staffs of the two departments.

The agreement signed by the two directors will be subject annually either to automatic reacceptance or to joint re-examination.

Edith Lindly Joins Fresno State Staff

Miss Edith Lindly has been appointed associate professor in health education at Fresno State College, where she will assist Dr. Elizabeth Kelly on the California Community Health Education Project.

Miss Lindly holds an M.P.H. from the University of Michigan and has experience in the fields of school health and public health education.

State, Local Agencies Share Mental Health Act Funds

Funds allotted to California under the National Mental Health Act of 1947 have been awarded to local and state agencies for improving existing mental health services, establishing new out-patient clinics and training specialized personnel.

The money was granted to each agency following a review of applications by a committee appointed by Dr. Wilton L. Halverson, State Mental Health Authority and Director of Public Health, and consisting of the following persons: Dr. Karl Bowman, Director, Langley Porter Clinic; Dr. Robert Dyar, Chief, Division of Preventive Medical Services, State Department of Public Health; Dr. Lawrence Kolb, Medical Deputy Director, State Department of Mental Hygiene; and Dr. Kent Zimmerman, Consultant for Mental Health, State Department of Public Health.

Local agencies receiving a share of the approximately $125,000 made available to California and the purposes for which the money will be used are:

1. *Kern County Health Department*—For a psychiatric social worker to work in the mental hygiene division and participate in the maternal and child health conferences and in monthly mental hygiene out-patient clinics in the major communities of the county.

2. *San Francisco City and County Health Department*—For a psychiatric social worker and for the training of a clinical psychologist in the psychiatric service of the San Francisco City Venereal Disease Clinic, where a study of the causative factors of promiscuity and methods of psychiatric and social treatment is carried out.

3. *Mount Zion Hospital, San Francisco*—For the training of two psychiatrists in the psychiatric clinic where emphasis is being placed on out-patient treatment of emotional disturbances in adults and children.

4. *Orange County Child Guidance Clinic*—For a psychiatric social worker to work in a clinic program which includes among its objectives the prevention of educational, emotional, and vocational maladjustments; a broad educational program involving the child, the family, and community groups; and the extension of resources to juvenile offenders.

5. *San Francisco Children's Hospital*—For a psychiatric social worker to work in the child guidance clinic, which offers diagnosis and treatment of problems in children, consultation with community agencies, and externship training for psychiatrists, psychiatric social workers, and psychologists.

6. *Los Angeles Psychiatric Service*—For a half-time psychiatrist and the training of two psychiatric social workers and of two clinical psychologists in clinic for psychiatric out-patient treatment of adult which is sponsored by the Community Chest of L Angeles.

Money allotted to state agencies will be used fo training personnel working in local public health pr grams and for the improvement and extension mental health services.

California Morbidity Report

December, 1947

Civilian Cases

Reportable diseases	Week ending					Total cases	5-yr. median	Tot
	12–6	12–13	12–20	12–27	1–3	Dec.	1942-1946 Dec.	De
Amebiasis (amoebic dysentery)	4	4	3	6	1	18	------	[illegible]
Anthrax	------	------	------	------	------	------	------	[illegible]
Botulism	------	------	------	------	------	------	------	[illegible]
Chancroid	17	13	12	9	7	58	------	[illegible]
Chickenpox (varicella)	706	661	834	650	387	3,238	2,995	[illegible]
Cholera, asiatic	------	------	------	------	------	------	------	[illegible]
Coccidioidal granuloma	------	7	------	------	1	8	------	[illegible]
Conjunctivitis—acute infectious of the newborn (ophthalmia neonatorum)	------	------	2	1	1	4	------	[illegible]
Dengue	------	------	------	------	------	------	------	[illegible]
Diarrhea of the newborn	------	10	5	7	5	27	------	[illegible]
Diphtheria	14	11	12	12	12	61	132	[illegible]
Dysentery, bacillary	4	1	8	3	2	18	------	[illegible]
Encephalitis, infectious	------	------	------	2	2	4	11	[illegible]
Epilepsy	54	47	24	22	29	176	------	[illegible]
Food poisoning	5	14	------	6	1	26	------	[illegible]
German measles (rubella)	45	52	45	36	32	210	------	[illegible]
Glanders	------	------	------	------	------	------	------	[illegible]
Gonococcus infection	680	567	479	489	422	2,637	1,792	[illegible]
Granuloma inguinale	2	3	------	------	3	8	------	[illegible]
Influenza, epidemic	11	97	55	134	376	673	175	[illegible]
Jaundice, infectious	1	3	2	2	1	9	------	[illegible]
Leprosy	------	------	------	------	1	1	------	[illegible]
Lymphogranuloma venereum (lymphopathia venereum, lymphogranuloma inguinale)	2	2	4	9	2	19	------	[illegible]
Malaria	------	------	2	4	------	6	14	[illegible]
Measles (rubeola)	227	326	225	271	280	1,329	705	[illegible]
Meningitis, meningococcic	2	3	8	4	14	31	53	[illegible]
Mumps (parotitis)	334	379	390	230	211	1,544	1,851	[illegible]
Paratyphoid fever, A, B and C	1	1	------	------	------	2	------	[illegible]
Plague	------	------	------	------	------	------	------	[illegible]
Pneumonia, infectious	25	42	36	35	33	171	358	[illegible]
Poliomyelitis, acute anterior	14	8	8	3	5	38	70	[illegible]
Psittacosis	------	------	------	------	1	1	------	[illegible]
Rabies, human	------	------	------	------	------	------	------	[illegible]
Rabies, animal	11	7	19	6	7	50	46	[illegible]
Relapsing fever	------	------	------	------	------	------	------	[illegible]
Rheumatic fever, acute	19	10	11	10	11	61	------	[illegible]
Rocky Mountain spotted fever	------	------	------	------	------	------	------	[illegible]
Scarlet fever	122	96	120	107	69	514	912	[illegible]
Septic sore throat	15	6	11	6	5	43	------	[illegible]
Smallpox (variola)	------	------	------	------	------	------	------	[illegible]
Syphilis	369	415	320	336	283	1,723	1,893	[illegible]
Tetanus	------	------	1	------	2	3	------	[illegible]
Trachoma	1	------	1	------	------	2	------	[illegible]
Trichinosis	4	4	4	1	1	14	------	[illegible]
Tuberculosis, pulmonary	145	131	132	108	192	708	618	[illegible]
Tuberculosis, other forms	11	8	15	7	39	80	62	[illegible]
Tularemia	------	------	------	------	------	------	------	[illegible]
Typhoid fever	3	2	4	2	4	15	8	[illegible]
Typhus fever	1	------	------	7	1	9	------	[illegible]
Undulant fever (brucellosis)	5	5	5	4	1	20	24	[illegible]
Whooping cough (pertussis)	125	106	117	87	52	487	430	[illegible]
Yellow fever	------	------	------	------	------	------	------	[illegible]
						14,046		[illegible]

printed in CALIFORNIA STATE PRINTING OFFICE 83777-C.1-48